



General Assembly

Amendment

January Session, 2009

LCO No. 8396

SB0004708396SD0

Offered by:

SEN. CRISCO, 17th Dist.

REP. FONTANA, 87th Dist.

REP. SCHOFIELD, 16th Dist.

To: Subst. Senate Bill No. 47

File No. 176

Cal. No. 201

**"AN ACT CONCERNING HEALTH CARE PROVIDER
CONTRACTS."**

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Section 38a-479 of the general statutes is repealed and the
4 following is substituted in lieu thereof (*Effective January 1, 2010*):

5 (a) As used in this section and section 2 of this act:

6 (1) "Contracting health organization" means [(A)] a managed care
7 organization, as defined in section 38a-478, or [(B)] a preferred
8 provider network, as defined in section 38a-479aa. [; and (2)
9 "physician" means a physician or surgeon, chiropractor, podiatrist,
10 psychologist or optometrist.]

11 (2) "Provider" means a physician, surgeon, chiropractor, podiatrist,
12 psychologist, optometrist, natureopath or advanced practice registered

13 nurse licensed in this state or a group or organization of such
14 individuals, who has entered into or renews a participating provider
15 contract with a contracting health organization to render services to
16 such organization's enrollees and enrollee's dependents.

17 (b) [Not later than October 1, 2007, each] Each contracting health
18 organization shall establish and implement a procedure [reasonably
19 designed to permit a physician, physician group or physician
20 organization under contract with such contracting health organization
21 to view, on a confidential basis, in a] to provide to each provider:

22 (1) Access via the Internet or other electronic or digital format [or by
23 electronic means, at the option of such organization, the fee-for-service
24 dollar amount such organization reimburses pursuant to the
25 organization's contract with the physician, physician group or
26 physician organization for the fifty current procedural terminology
27 codes most commonly performed by the physician, physician group or
28 physician organization] to the contracting health organization's fees for
29 (A) the current procedural terminology (CPT) codes applicable to such
30 provider's specialty, (B) the Health Care Procedure Coding System
31 (HCPCS) codes applicable to such provider, and (C) such CPT codes
32 and HCPCS codes as may be requested by such provider for other
33 services such provider actually bills or intends to bill the contracting
34 health organization, provided such codes are within the provider's
35 specialty or subspecialty; and

36 (2) Access via the Internet or other electronic or digital format to the
37 contracting health organization's policies and procedures regarding
38 (A) payments to providers, (B) providers' duties and requirements
39 under the participating provider contract, (C) inquiries and appeals
40 from providers, including contact information for the office or offices
41 responsible for responding to such inquiries or appeals and a
42 description of the rights of a provider, enrollee and enrollee's
43 dependents with respect to an appeal.

44 [(c) The procedure established by a contracting health organization

45 shall also permit a physician, physician group or physician
46 organization to request and view fee-for-service dollar amounts the
47 contracting health organization reimburses for current procedural
48 terminology codes for which a physician, physician group or physician
49 organization actually bills or intends to bill the contracting health
50 organization, provided such codes are within the physician's, group's
51 or organization's specialty or subspecialty.]

52 [(d)] (c) The provisions of [subsections (b) and (c)] subdivision (1) of
53 subsection (b) of this section shall not apply to any [physician,
54 physician group or physician organization] provider whose services
55 are reimbursed in a manner that does not utilize current procedural
56 terminology codes.

57 [(e)] (d) The fee information received by a [physician, physician
58 group or physician organization] provider pursuant to subdivision (1)
59 of subsection (b) of this section is proprietary and shall be confidential,
60 and the procedure adopted pursuant to this section may contain
61 penalties for the unauthorized distribution of fee information, which
62 may include termination [from the contracting health organization
63 network] of the participating provider contract.

64 Sec. 2. (NEW) (*Effective July 1, 2010*) (a) No contracting health
65 organization shall make material changes to a provider's fee schedule
66 except as follows:

67 (1) At one time annually, provided providers are given at least
68 ninety days' advance notice by mail, electronic mail or facsimile by
69 such organization of any such changes. Upon receipt of such notice, a
70 provider may terminate the participating provider contract with at
71 least sixty days' advance written notice to the contracting health
72 organization;

73 (2) At any time for the following, provided providers are given at
74 least thirty days' advance notice by mail, electronic mail or facsimile by
75 such organization of any such changes:

76 (A) To comply with requirements of federal or state law, regulation
77 or policy. If such federal or state law, regulation or policy takes effect
78 in less than thirty days, the organization shall give providers as much
79 notice as possible;

80 (B) To comply with changes to the medical data code sets set forth
81 in 45 CFR 162.1002, as amended from time to time;

82 (C) To comply with changes to national best practice protocols made
83 by the National Quality Forum or other national accrediting or
84 standard-setting organization based on peer-reviewed medical
85 literature generally recognized by the relevant medical community or
86 the results of clinical trials generally recognized and accepted by the
87 relevant medical community;

88 (D) To be consistent with changes made in Medicare pertaining to
89 billing or medical management practices, provided any such changes
90 are applied to relevant participating provider contracts where such
91 changes pertain to the same specialty or payment methodology;

92 (E) If a drug, treatment, procedure or device is identified as no
93 longer safe and effective by the federal Food and Drug Administration
94 or by peer-reviewed medical literature generally recognized by the
95 relevant medical community;

96 (F) To address payment or reimbursement for a new drug,
97 treatment, procedure or device that becomes available and is
98 determined to be safe and effective by the federal Food and Drug
99 Administration or by peer-reviewed medical literature generally
100 recognized by the relevant medical community; or

101 (G) As mutually agreed to by the contracting health organization
102 and the provider. If the contracting health organization and the
103 provider do not mutually agree, the provider's current fee schedule
104 shall remain in force until the annual change permitted pursuant to
105 subdivision (1) of this subsection.

106 (b) (1) No contracting health organization shall cancel, deny or
107 demand the return of full or partial payment for an authorized covered
108 service due to administrative or eligibility error, more than eighteen
109 months after the date of the receipt of a clean claim, except if:

110 (A) Such organization has a documented basis to believe that such
111 claim was submitted fraudulently by such provider;

112 (B) The provider did not bill appropriately for such claim based on
113 the documentation or evidence of what medical service was actually
114 provided;

115 (C) Such organization already paid the provider for such claim;

116 (D) Such organization paid a claim that should have been or was
117 paid by a federal or state program; or

118 (E) The provider received payment for such claim from a different
119 insurer, payor or administrator through coordination of benefits or
120 subrogation, or due to coverage under an automobile insurance or
121 workers' compensation policy. Such provider shall have one year after
122 the date of the cancellation, denial or return of full or partial payment
123 to resubmit an adjusted secondary payor claim with such organization
124 on a secondary payor basis, regardless of such organization's timely
125 filing requirements.

126 (2) (A) Such organization shall give at least thirty days' advance
127 notice to a provider by mail, electronic mail or facsimile of the
128 organization's cancellation, denial or demand for the return of full or
129 partial payment pursuant to subdivision (1) of this subsection.

130 (B) If such organization demands the return of full or partial
131 payment from a provider, the notice required under subparagraph (A)
132 of this subdivision shall disclose to the provider (i) the amount that is
133 demanded to be returned, (ii) the claim that is the subject of such
134 demand, and (iii) the basis on which such return is being demanded.

135 (C) Not later than thirty days after the receipt of the notice required

136 under subparagraph (A) of this subdivision, a provider may appeal
 137 such cancellation, denial or demand in accordance with the procedures
 138 provided by such organization. Any demand for the return of full or
 139 partial payment shall be stayed during the pendency of such appeal.

140 (D) If there is no appeal or an appeal is denied, such provider may
 141 resubmit an adjusted claim, if applicable, to such organization, not
 142 later than thirty days after the receipt of the notice required under
 143 subparagraph (A) of this subdivision or the denial of the appeal,
 144 whichever is applicable, except that if a return of payment was
 145 demanded pursuant to subparagraph (C) of subdivision (1) of this
 146 subsection, such claim shall not be resubmitted.

147 (E) A provider shall have one year after the date of the written
 148 notice set forth in subparagraph (A) of this subdivision to identify any
 149 other appropriate insurance coverage applicable on the date of service
 150 and to file a claim with such insurer, health care center or other issuing
 151 entity, regardless of such insurer's, health care center's or other issuing
 152 entity's timely filing requirements.

153 (c) The provisions of subsection (c) of section 38a-193 of the general
 154 statutes shall apply to a participating provider contract issued by a
 155 health care center under section 38a-479 of the general statutes, as
 156 amended by this act, and this section."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2010</i>	38a-479
Sec. 2	<i>July 1, 2010</i>	New section